**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4812 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

PINE CREEK MEDICAL CENTER
5201 GREEN STREET SUITE 215
SALT LAKE CITY UT 84123

**Respondent Name**
TEXAS MUTUAL INSURANCE CO

**Carrier's Austin Representative Box**
Box Number 54

**MFDR Tracking Number**
M4-07-0584-01

**MFDR Date Received**
AUGUST 28, 2006

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "PRIM DIAG 805.2 FAIR AND REASONABLE"

**Requestor's Supplemental Position Summary dated October 16, 2006**: "Please note, there is no additional information to submit at this time."

**Amount in Dispute:** $103,983.84

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary dated September 18, 2006:** "The principal diagnosis code in box 67 of the requestor's bill is 805.2, vertebral fracture. This diagnosis code converts the payment to one of a fair and reasonable nature versus per diem or stop loss." "Texas Mutual paid ***$22,656.80***, an amount that appears more than fair and reasonable."

**Respondent's Position Summary dated September 8, 2011:** "All acute care inpatient admissions today are based on a derivative of Medicare's inpatient prospective payment system. That system does not distinguish payment reimbursement on the basis of trauma or non-trauma. Today the reimbursement from Medicare for the DRG given by the requestor on its bill is $16,247.73. DWC added a payment adjustment factor of 1.43 that is multiplied by the $16,247.73 to obtain a total reimbursement of $23,243.25. And today this would be considered a fair and reasonable reimbursement." "Therefore, no additional payment is due."

**Response Submitted by:** Texas Mutual Insurance Co., 6210 E. Hwy 290, Austin, TX 78723

## *SUMMARY OF FINDINGS*

| Date(s) of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| August 29, 2005 through September 1, 2005 | Inpatient Services | $103,983.84 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401 sets out the fee guideline for acute care inpatient hospital services.
3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. This request for medical fee dispute resolution was received by the Division on August 28, 2006. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on October 9, 2006 to send additional documentation relevant to the fee dispute as set forth in the rule.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - Billed charges do not meet the stop-loss method standard of the 08/01/97 Acute Care Inpatient Hospital Fee Guideline. The charges do not indicate an unusually costly or unusually extensive hospital stay. The intent of stop-loss payment is to compensate hospitals for impatient s.
   - CAC- W1-Workers Compensation state fee schedule adjustment.
   - CAC-W10-No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
   - CAC-W4-No additional reimbursement allowed after review of appeal/reconsideration.
   - CAC-97-Payment is included in the allowance for another service/procedure.
   - 480-Reimbursement based on the Acute Care Inpatient Hospital Fee Guideline per diem rate allowances.
   - 719-Reimbursed at carrier's fair & reasonable; cost data unavailable for facility. Additional payment may be considered if data submitted.
   - 730-Denied as included in per diem rate.
   - 891-The insurance company is reducing or denying payment after reconsideration.
   - CAC-18-Duplicate claim/service.
   - 878-Duplicate appeal. Request medical dispute resolution through DWC for continued disagreement of original appeal decision.

**Findings**

1. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 805.2. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
2. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's seeks full reimbursement of billed charges based upon "PRIM DIAG 805.2 FAIR AND REASONABLE."

- The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
- Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
- The Division has previously found that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors," as stated in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276. It further states that "Alternative methods of reimbursement were considered… and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges…" 22 *Texas Register* 6268-6269. Therefore, the use of a hospital's "usual and customary" charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

**Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

**Authorized Signature**

| | | |
|---|---|---|
| | | 10/25/2012 |
| Signature | Medical Fee Dispute Resolution Officer | Date |
| | | 10/25/2012 |
| Signature | Health Care Business Management Director | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.